DAKOTA PLAN & DAKOTA RETIREE PLAN

This publication is intended to provide general information and may not be considered to be a legal interpretation of law. Statements contained in this publication do not supersede the North Dakota Century Code or Administrative Code or restrict the authority granted to the Retirement Board. Refer to the Plan Document for complete details.

ELIGIBILITY

To be eligible to join the Dakota Plan or the Dakota Retiree Plan:

A member must be receiving a "retirement allowance" from:

- North Dakota Public Employees Retirement System (NDPERS)
  - Defined Benefit Plan
  - Defined Contribution Plan
- North Dakota Highway Patrol Retirement System (NDHPRS)
- Job Service Retirement Plan
- Teacher's Fund for Retirement (TFFR)
- Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-CREF)

A member of certain Political Subdivisions, if enrolled in the Dakota Plan as an active employee, and:

- Receiving a "retirement allowance" from a NDPERS Board approved employer sponsored retirement plan, such as:
  - 401(a)
  - 401(k)
  - 403(b)
  - 457

A surviving spouse must be:

- Receiving a beneficiary benefit from the aforementioned retirement plans, or
- On the Dakota Plan as a covered dependent at the time of member's death and there is no lapse in coverage.

A non-spouse beneficiary is not eligible to continue on the group health plan.

ENROLLMENT

A member or surviving spouse, receiving a retirement allowance, must apply for coverage within 31 days from any one of the following "qualifying events":

1. Date of retirement, defined as either:

   The last day of active employment if member does not defer his/her retirement benefit or take a lump-sum refund of his/her retirement account, or

   Date of first retirement check if member deferred his/her retirement benefit.
2. Member's 65th birthday or eligibility for Medicare;
3. Member's spouse or eligible dependent's 65th birthday or eligibility for Medicare;
4. The loss of coverage in a health plan sponsored or provided by member's employer or member's spouse's employer, if covered through spouse's employer group plan. This includes loss of coverage due to the death of, or divorce from a spouse as well as completion of COBRA continuation coverage.
5. Marriage
6. Birth, adoption, or appointment of children for legal guardianship.

If a member or surviving spouse does not enroll within 31 days of any one of the above qualifying events, he/she will have forfeited his/her rights to enroll in the Plan in the future.

COVERAGE EFFECTIVE DATE

If a member is enrolled in the Dakota Plan as an active employee, coverage will become effective on the first of the month following the final date of coverage provided by his/her employer. If a member was not enrolled in the Dakota Plan at the time of application, coverage will become effective on the first day of the month following one of the "qualifying events" listed in the enrollment section above.

PREMIUM PAYMENT POLICY

Retirement Plan	Payment Method
NDPERS Defined Benefit[1]	Deduct from Benefit Check Deduct from Bank Account
NDPERS Defined Contribution[3]	Deduct from Bank Account
NDHPRS[1]	Deduct from Benefit Check Deduct from Bank Account
Job Service[1]	Deduct from Benefit Check Deduct from Bank Account
TFFR[2]	Deduct from Benefit Check Deduct from Bank Account
TIAA-CREF[3]	Deduct from Bank Account
Approved Employer Sponsored[3]	Deduct from Bank Account

1. If retirement allowance is large enough to deduct the entire monthly premium, the premium will automatically be withheld from the benefit check. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an "Authorization for Automatic Premium Deduction SFN 50134.

2. If TFFR retirement allowance is large enough to deduct the entire monthly premium, an election to have premiums withheld from a benefit check must be made. Complete an "Payroll Deduction Authorization (313) SFN 19182". If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an "Authorization for Automatic Premium Deduction SFN 50134.

3. If retirement allowance is issued from the NDPERS Defined Contribution plan, TIAA-CREF, or a Board approved employer sponsored retirement plan, premiums must be withheld from a bank account. Complete an "Authorization for Automatic Premium Deduction SFN 50134.

CANCELLATION POLICY

To cancel NDPERS health coverage, a written request must be submitted. The request must provide the contract holder's name, contract number and effective date. NDPERS must receive a cancellation request by the 15th of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

DAKOTA PLAN

COBRA CONTINUATION

A member is eligible for COBRA continuation if enrolled in the Dakota Plan as an active employee. A member may continue coverage for 18 months under COBRA or until the member or their covered dependent(s) become eligible for Medicare, whichever occurs first. Options will vary based on the following:

- A member **deferred his/her retirement allowance or took a lump sum payment** of retirement account. After the 18 months has expired and if member is not yet receiving a retirement allowance from one of the eligible retirement systems listed previously, he/she has the option to enroll under a conversion health plan. For details about the conversion option, contact BCBSND at 1-800-223-1704.

- A member elects to begin receiving **a retirement allowance immediately** from an eligible retirement system. At the conclusion of the 18 months or when member or eligible dependent becomes eligible for Medicare, the option to enroll in the Dakota Plan or the Dakota Retiree Plan becomes available, subject to the eligibility requirements.

The following COBRA premiums are in effect through June 30, 2007:

	Single	**Family**
State Agencies	$266.18	$656.50
Political Subdivisions, enrolled prior to July 1, 2005	$278.70	$687.70
Political Subdivisions, enrolled after July 1, 2005*****	$281.64	$678.18
EPO Only Groups, enrolled prior to July 1, 2005	$258.86	$638.94
EPO Only Groups, enrolled after July 1, 2005*****	$262.20	$631.12

*****Subject to rate increases July 1, 2006

If eligibility continues upon completion of COBRA, and you are not eligible for Medicare, the following premiums are in effect through June 30, 2007:

	Single	**Family**
Non-Medicare	$390.92	$781.86
Non-Medicare (3 or more)	$977.32	

EXTENDED COBRA

Disability

A member or their dependent determined to have been disabled for Social Security purposes may extend the continuation of coverage to 29 months. If member or their dependent becomes disabled at any time during the first 60 days of COBRA continuation coverage the member must provide notice of such determination to NDPERS within 60 days after the date of any final determination of disability and before the end of the 18 month continution period.

Death

Continuation of coverage may be extended for a period up to 36 months for an eligible dependent.

CANCELLATION OF COBRA

Coverage may be cancelled when a person receiving continuation of coverage becomes covered under another benefit plan providing the same or similar coverage.

DAKOTA PLAN FEATURES

Preferred Provider Organization (PPO)

The Preferred Provider Organization (PPO) is a group of hospitals, clinics and physicians who have agreed to discount their services to members of NDPERS. You have "freedom of choice" in selecting which physician or medical facility to use for services. No referral is needed. If you choose a provider who participates in the PPO program, you will have lower out-of-pocket expenses. PPO benefits are only available in the State of North Dakota, unless the medical facility provides services at a satellite location in another State.

Exclusive Provider Organization (EPO)

The Exclusive Provider Organization (EPO) is a managed care program and encourages the use of a Primary Care Physician. You and each of your eligible family members may use any Primary Care Physician affiliated with your designated EPO provider. You may change your Primary Care Physicians at any time. The medical practices included under primary care are: General/Family Practice, Obstetrics/Gynecology, Pediatrics and Internal Medicine. If you enroll in the EPO you will have lower out-of-pocket expenses for annual deductibles and reduced copayments for office visits and diagnostic services. Your affiliation is for one year and you must reside in a 50 mile radius of an EPO provider. The plan year runs from July 1 through June 30 of the following year.

A retiree may continue their EPO coverage if they participated in the EPO program as an active employee. The EPO coverage terminates upon completion of COBRA or entitlement to Medicare, whichever occurs first.

Plan Features:	**Basic (Self Referral or Out-of-State)**	**PPO**	**EPO***
Deductible for All Services			
-Per Person	$250	$250	$100
-Per Family	$750	$750	$300
Copayment for Physician Office Visits (no limit)	$ 25	$ 20	$ 15
Copayment for Emergency Room	$ 50	$ 50	$ 50
Coinsurance on all covered services **EXCEPT** Physician Office Visits	75/25	80/20	85/15
Annual Coinsurance Maximum			
-Individual	$1250	$750	$500
-Family	$2500	$1500	$1000
Out-of-Pocket Maximums (Deductible and Coinsurance)**			
-Individual	$1500	$1000	$600
-Family	$3250	$2250	$1300

***** Out-of-network coverage is at the Basic level.

**Office visit and emergency room copayments and prescription drug copayments and coinsurance are additional.

DEDUCTIBLE AND COINSURANCE

Deductible, copayments, and coinsurance maximums accrue on a "Calendar-Year" basis, January 1 - December 31.

Prescription Formulary Generic Drug			
-Copayment	$5	$5	$5
-Coinsurance ($1,000 maximum per person per benefit period, covered at 100% after $1,000 out of pocket is met)	15%	15%	15%
Prescription Formulary Brand-Name Drug***			
-Copayment	$15	$15	$15
-Coinsurance ($1,000 maximum per person per benefit period, covered at 100% after $1,000 out of pocket is met)	25%	25%	25%
Prescription Non-Formulary Drug			
-Copayment	$25	$25	$25
-Coinsurance	50%	50%	50%

******* For each 30-day supply or 100 units of an authorized maintenance drug or non-prescription diabetic supplies.

PREVENTIVE SCREENING SERVICES

The following services are paid at 100% of allowed charge. The deductible amount is waived.

Planned Screening includes these tests:	**Frequency**
Blood Sugar Testing (blood test used to screen for diabetes and other conditions) **Total Serum Cholesterol Testing** (identifies risk factors for coronary artery disease) **Fecal Occult Blood Testing** (test used to screen for colon cancer)	**Under age 40:** Once every five years. **Ages 40 - 64:** Once every two years. **Ages 65 and over:** Once a year.
Mammography Screening (test for breast tumors)	**Ages 35 - 40:** One service for members between the ages of 35 - 40. **Ages 40 - 50:** Once every 24 months. **Ages 50 and over:** Once a year.
Routine Pap Smear (test for cervical cancer)	**Once a year.**

DAKOTA RETIREE PLAN

The Dakota Retiree Plan is a "Carve-Out" plan that pays secondary to Medicare. It is not a supplemental plan. As secondary payer, there will be an adjustment to the premium if transitioning from the Dakota Plan.

A member or eligible dependent may enroll in this health coverage at the time of Medicare eligibility. If covered under the Dakota Plan at the time, a member will receive a notification approximately 60 days prior to the eligibility date regarding the enrollment procedures. To enroll, the following requirements must be met:

- The eligible member/dependent must have both parts A and B of Medicare. If the eligible member/dependent continues to be covered by an "active" employer group policy, Medicare Part B may be waived until the contract holder terminates employment.

- The eligible member/dependent must complete an application and include a copy of the Medicare card.

If the above requirements are met and member enrolls prior to July 1, 2005, or transitions from COBRA or the Dakota Plan, the following premiums are in effect through June 30, 2007:

	Single	**Family**
One Medicare/One Non-Medicare		$537.90
Medicare Eligible (must have both Medicare A & B)	$218.40	$427.24

If the above requirements are met and member enrolls in the plan on or after July 1, 2005 the following premiums are in effect through June 30, 2006 [See rates below for July 1, 2006 through June 30, 2007]:

	Single	**Family**
One Medicare/One Non-Medicare		$548.44
Medicare Eligible (must have both Medicare A & B)	$223.72	$435.98

If the above requirements are met and member enrolls in the plan on or after July 1, 2006 the following premiums are in effect through June 30, 2007:

	Single	**Family**
One Medicare/One Non-Medicare		$620.94
Medicare Eligible (must have both Medicare A & B)	$248.32	$483.92

If member/dependent did not enroll in the plan at the time he/she is eligible, coverage will cease on the first day of the month in which the member or dependent(s) became eligible.

DAKOTA RETIREE PLAN FEATURES

The **Dakota Retiree Plan** provides health care coverage as a secondary payer to Medicare. The **Dakota Retiree Plan** differs from the regular Federal Supplement plans A through J in that it does not pay 100% of the balance of Medicare's approved charges. The following is a brief description of benefits as provided by the plan when paying secondary to Medicare. Please note that the **Dakota Retiree Plan** provides prescription drug coverage. To continue coverage with the NDPERS Dakota Retiree Plan a member or dependent must carry both Parts A and B of Medicare when he/she becomes eligible for Medicare benefits. If member or dependent is eligible for Medicare but continues to be covered by an "active" employer group policy, Medicare Part B may be waived until the contract holder terminates from employment.

TYPE OF SERVICE	***MEDICARE PAYS – Effective 1/1/2004***	***DAKOTA RETIREE PLAN PAYS***	
		In State PPO Provider	Non PPO Provider or Out of State
INPATIENT **HOSPITAL SERVICES** Includes semi-private room and board, general nursing and miscellaneous hospital services and supplies.	A benefit period begins on the first day you receive service as an impatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. The following is based on a benefit period. •First 60 days : all but $876 •61st thru 90th day : all but $219 a day •91st thru 150th day : all but $438 a day •All costs for each day beyond 150 days	Dakota Plan pays 80% after the annual $250 deductible. For any subsequent illness where Medicare's deductible is applied again, Dakota Plan pays 80%.	Dakota Plan pays 75% after the annual $250 deductible. For any subsequent illness where Medicare'' deductible is applied again, Dakota Plan pays 75%.
OUTPATIENT HOSPITAL SERVICES & SUPPLIES Includes services for first-aid emergency care, laboratory and x-ray tests, surgical procedures, radiation therapy, home health visits, ambulance, and durable medical equipment such as oxygen equipment and wheelchairs.	Outpatient services are covered when provided for and billed by a hospital, subject to the Medicare Part B annual $100 deductible and 20% coinsurance	Dakota Plan pays eligible expenses at 80%, subject to an annual $250 deductible (combined with inpatient services).	Dakota Plan pays eligible expenses at 75%, subject to an annual $250 deductible (combined with inpatient services).
EXTENDED **CARE/HOME HEALTH**	Skilled Nursing Facility – In each benefit period, Medicare Part A may pay for all covered services for the first 20 days you are in a skilled nursing facility. For the 21st – 100th day, Medicare Part A copayment is $109.50 per day. Home Health Care – Unlimited home health visits if all Medicare guidelines have been met.	Unlimited days for Skilled Nursing Facilities and Home Health Care for medically necessary (skilled) services paid at 80%, subject to an annual $250 deductible (combined with in-outpatient services). No coverage for intermediate and/or custodial care.	Unlimited days for Skilled Nursing Facilities and Home Health Care for medically necessary (skilled) services paid at 75%, subject to an annual $250 deductible (combined with in-outpatient services). No coverage for intermediate and/or custodial care.
AVAILABLE PHYSICIAN, MEDICAL SERVICES AND SUPPLIES Includes physician services wherever provided – in-home, hospital, or office; diagnostic x-ray and lab tests; physical and speech therapy; medical supplies such as splints and casts, certain prosthetic devices; artificial limbs and eyes.	You pay the first $100 per year – Medicare Part B (medical insurance) then pays 80% of the remaining allowable charges for covered services as determined by Medicare Part B.	Dakota Plan pays 80% of allowable charges on Medicare's balance.	Dakota Plan pays 75% of allowable charges on Medicare's balance.
PRESCRIPTION DRUGS	Inpatient prescription drugs only. No coverage for outpatient prescription drugs.	Prescription Drugs – Retail or mail order for each 34 day supply or 100 units of an authorized maintenance drug: **Formulary:** **Copayment** **Coinsurance** Brand-name drug $15 25% of allowable charge* Generic drug $5 15% of allowable charge* * Covered at 100% after $1,000 out of pocket coinsurance maximum is met **Non-Formulary:** $25 50% of allowable charge Members pay the difference between generic and brand-name price if brand-name drug is purchased and generic is available.	

DEFINITIONS

CLASS OF COVERAGE - the type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Classes of Coverage are as follows:

A. **Single Coverage** - Subscriber only.
B. **Family Coverage** - Subscriber and Eligible Dependents.

ELIGIBLE DEPENDENT - a dependent of the Subscriber who qualifies for membership under this Benefit Plan in accordance with the requirements specified below:

A. The Subscriber's spouse under a legally existing marriage between persons of the opposite sex.
B. The Subscriber's or the Subscriber's living, covered spouse's unmarried children under the age of 23 years who are financially dependent on the Subscriber or the Subscriber's spouse. Children are considered under age 23 until the end of the month in which the child becomes 23 years of age. The term child or children includes:

1. Children physically placed with the Subscriber for adoption or whom the Subscriber or the Subscriber's living, covered spouse has legally adopted.
2. Children living with the Subscriber for whom the Subscriber or the Subscriber's living, covered spouse has been appointed legal guardian by court order.
3. The Subscriber's grandchildren or those of the Subscriber's living, covered spouse if: (a) the parent of the grandchild is a covered Eligible Dependent under this Benefit Plan and (b) both the parent and the grandchild are primarily dependent on the Subscriber for support. If a lapse in coverage occurs due to ineligibility of the parent under this Benefit Plan, the grandchild cannot be reenrolled unless the Subscriber has been appointed legal guardian.
4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits.
5. Children beyond the age of 23 who are full-time students at accredited institutions who are financially dependent on the Subscriber or the Subscriber's spouse. Coverage in such cases will be continued only until the end of the month in which the child becomes 26 years of age.
6. Children beyond the age of 23 who are incapable of self support because of mental retardation or physical handicap that began before the child attained age 23 and who are primarily dependent on the Subscriber or the Subscriber's spouse for support. Coverage for such a disabled child will continue for as long as the child remains unmarried, disabled and the Subscriber's dependent for federal income tax purposes. The Subscriber may be asked periodically to provide evidence satisfactory to BCBSND of these disabilities.

A Member will in no event be an Eligible Dependent of more than one employee. A dependent of an employee will not be eligible if that dependent is also an employee.

MEMBER - the Subscriber and, if another Class of Coverage is in force, the Subscriber's Eligible Dependents.

PAY STATUS - a Subscriber/surviving spouse receiving a retirement allowance from an eligible retirement plan.

RETIREE – a Subscriber receiving a monthly retirement allowance pursuant to chapter 54-52.

RETIREMENT - the acceptance of a retirement allowance upon either termination of employment or termination of participation in the retirement plan and meeting the normal retirement date.

RETIREMENT ALLOWANCE- a reoccurring, periodic benefit from an eligible employer sponsored retirement plan.

SURVIVING SPOUSE - a legal spouse of the deceased member.

SUBSCRIBER - the individual whose application for membership has been accepted, whose coverage is in force with BCBSND and in whose name the Identification Card and Benefit Plan Attachment are issued.